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ABSTRACT

This report promotes one-stop shopping for health and social services as an effective strategy for accommodating the needs of pregnant women and their children. Roadblocks to receipt of care by pregnant women include ignorance of prenatal or preventive pediatric services, poverty, weak referral networks, and the fragmentation of programs and services. A roadblock to coordination of services is created through administration of programs by multiple agencies. Five tools are needed to better bring services to families in need. First, there must be strong professional and political leadership. Second, the route to receiving care can be simplified by means of shortened and joint applications, expedited eligibility determinations, use of computers, and outreach programs. Third, bridges can be built between families and services through case management and interagency partnerships. Fourth, short cuts to receiving care can be effected by the placing of services under one roof, as in community health centers and public health clinics. Fifth, the capacity of the health delivery system must be expanded. Recommendations for designing one-stop shopping and short cuts for health service delivery are offered. Appendixes describe several model health care and support programs. A list of 36 references is included. (BC)

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ONE-STOP SHOPPING:

THE ROAD TO HEALTHY MOTHERS AND CHILDREN

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The National Commission to Prevent Infant Mortality

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ONE-STOP SHOPPING:
THE ROAD TO HEALTHY MOTHERS AND CHILDREN

Illustration by Annie Lunsford

A Report of
The National Commission to Prevent Infant Mortality

April 1991

Governor Lawton Chiles (Fl), Chairman

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INTRODUCTION

DEPARTMENT STORES...SHOPPING MALLS...

MINI MARTS AT GAS STATIONS...COMPUTER MODEMS...

LAUNDROMAT/GYMNASIUMS...MOTOR/VOTER REGISTRATION...

STAMP MACHINES IN SUBWAYS...ATM MACHINES IN

SUPERMARKETS...FULL SERVICE BEAUTY SALONS...

Business and marketing strategists have listened closely to consumer demands and have responded with a number of convenient, accessible, "user friendly" service systems. They take great pains to ensure that multiple services are readily accessible through a single point of entry.

However, our society has failed to apply the same determined, creative energies to making other more fundamental services, namely health and social services, convenient and accessible to families in need. Despite the fact that numerous studies, demonstration projects, and programs have unveiled a clear relationship between ease in obtaining services and the number of individuals using and benefiting from those services, translating this knowledge into action has yet to become a priority in the United States. The results are too costly, both in lives and dollars, to wait any longer.

The National Commission to Prevent Infant Mortality believes that universal access to care for all pregnant women and infants is critical in order to reduce our tragically high infant mortality and morbidity rates. However, the experience of women and children seeking health and social services often mirrors the cover of this rep[illegible] they must negotiate a complex, fragmented, disorganize[illegible]oad map of programs, with little, if any, constructive guidance. Far too many women and children venture up the wrong roads, encounter detours

and road blocks, get lost, or run out of toll money or fuel and never gain access to the services they need. These barriers help explain why many thousands of women go without prenatal care, hundreds of thousands have low birthweight babies, and the nation's infant mortality rate remains higher than the rates of so many other industrialized countries.

This report promotes **ONE-STOP SHOPPING** as an effective strategy for accommodating — rather than just tolerating — the needs of pregnant women and their children. The first part of the report, "The Case for One Stop Shopping," paints a vivid picture of the barriers to both gaining access and coordinating health and social service programs. The concept of integrating services is not new, but the current situation heightens the imperative to take action. Part One concludes by defining one-stop shopping as a dynamic, multi-faceted strategy, rather than as one formal method of service delivery.

Because there is no single road map for creating a one-stop shopping strategy, Part Two, "Designing One-Stop Shopping," discusses methods for connecting various programs systematically, and for linking the resulting "system" with the population it is intended to serve.

Examples of several one-stop shopping strategies are described in this report. They helped shape the report's recommendations which are directed to policymakers, community leaders, and those working directly with childbearing women and their families.

It is our hope that this report will help spur the kind of creativity and leadership necessary for redesigning the service delivery road map. We must build on our understanding of coordinating services, forge new alliances, and commit to making the health of women and children a priority in order to eliminate the roadblocks and make the process of obtaining care a smoother journey. It is an investment in the future for all of us.

THE AMERICAN HEALTH CARE SYSTEM IS COMMONLY CRITICIZED FOR DELIVERING SERVICES IN A FRAGMENTED AND DISORGANIZED MANNER.... [THIS PROBLEM] IS ESPECIALLY PREVALENT IN THE PUBLIC PROGRAMS THAT SERVE THE NEEDIEST OF AMERICANS AND THAT OPERATE UNDER VERY COMPLEX AND ARCANE REGULATIONS.

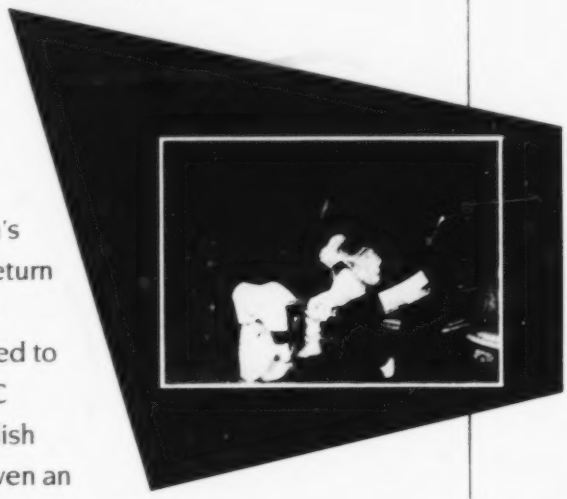
(*National Governors' Association, Coordinating Prenatal Care, p.3*)

PART I

THE CASE FOR ONE-STOP SHOPPING

Case Study

In January 1988, Jolene wasn't feeling well and wanted a pregnancy test. However, because the local public health clinic only offered tests on certain days of the week which were inconvenient for her, she went to a local Planned Parenthood. After learning she was pregnant, Jolene began seeking out services. Her first stop was at the Food Stamp office. While there, she learned about AFDC benefits and was referred to another service center to apply for them and for Medicaid.



She next went to the community Women's Center for prenatal care, only to be told to return in two weeks for an eligibility determination appointment. When she did, she was referred to the Central Clinic downtown to apply for WIC services and to University Hospital to establish hospitalization eligibility. She was finally given an appointment for three weeks later at the Women's Center, and was told to go back to the downtown Central Clinic for an HIV test.

After giving birth, Jolene returned for family planning services, but found that they were only provided two days per week. All told, Jolene made nine trips in six weeks to begin care and receive Medicaid eligibility.

Jolene's experience may sound unusual but, unfortunately, it is not. Reports of pregnant women and children visiting one office to apply for Medicaid, another to apply for WIC (the Special Supplemental Food Program for Women, Infants, and Children), and another for other programs, only to find that they must complete complex, often redundant eligibility forms at each, are commonplace. Then, gaining access to actual services often requires yet another round of trips. Lack of referral systems between providers makes the entire process even more difficult and ineffective. All too often a positive pregnancy test turns out to be the end — rather than the beginning — of a woman's contact with perinatal and pediatric services.

The impact of the fragmentation in health and social service delivery is reflected in several troubling statistics:

- The percentage of women receiving early and regular prenatal care has not improved in the past decade. One out of three pregnant women (some 1.3 million each year) receives inadequate prenatal care. In fact, in 1988, nearly 73,000 pregnant women in the U.S. received no prenatal care at all — a 50 percent increase over the 1980 rate.
- During the last decade, the United States' infant mortality rate has nearly stagnated and remains unacceptably high. In 1988 the United States ranked a dismal 21st among industrialized nations in infant mortality.
- The primary factor contributing to infant mortality is low birthweight (babies born weighing less than 5½ pounds). While low birthweight babies make up less than 7 percent of all newborns in the United States, they account for approximately 60 percent of all infant deaths.

Low birthweight is largely preventable by early, regular, and comprehensive prenatal care. But, as Jolene's experience typifies, there are "potholes" in service delivery that prevent even the most determined women from obtaining the care they need.

Roadblocks to Care

Numerous barriers stand between pregnant women and children and the care they need. The inability to pay for services causes many women to delay or even forgo prenatal care. Although eligibility for the Medicaid program has been expanded in recent years, millions of women and children remain uninsured. It has been estimated that 9.5 million women of reproductive age have no insurance at all, and about 11 million children below 18 years of age are uninsured.

Women also may not know the importance of prenatal or preventive pediatric care. And, "until a woman knows what her options are, she has no choices to make," notes Toni Berg.

Health Director at the New Futures School in Albuquerque, New Mexico.

A woman and her family may be overwhelmed by the stresses of poverty. Concerns about feeding, clothing, and caring for the family, plus unemployment, crime, and other issues can easily override the importance of prenatal care for many women.

Even if she does seek care, the "system" may be inadequate to meet her or her children's needs.

- There may be insufficient physicians, certified nurse-midwives, or nurse practitioners in the clinic or the community. This is especially problematic in rural and inner city areas. In fact, in some frontier areas, the WIC program may be the only health-related program for miles around. Funding for WIC overall is limited, and the program does not reach everyone in need.
- Physicians may refuse to accept Medicaid, or they may have dropped their obstetrical practice altogether due to the high cost of malpractice insurance.
- Communities may lack treatment programs for drug-addicted pregnant women. Although many may be eligible for Medicaid, coverage of substance abuse treatment is very limited.

Coupled with weak or non-existent referral networks, the result is long waiting lists at best, and at worst, no care at all. Other barriers to care include a lack of transportation, no child care, inconvenient service hours, and language and cultural barriers.

In addition to these monumental barriers — and probably, in part, the cause of them — is the fragmentation of programs and services for pregnant women and children. The woman who qualifies for Medicaid is often the same one who is eligible for WIC, housing assistance, and other programs. Yet, these and other programs that have been established to serve women and children often operate on completely different tracks. They have different application processes, eligibility requirements, and terminologies. Each is designed to treat a specific symptom, not an entire person.

Even on their own, some programs, such as Medicaid, are overwhelmingly complex. Indeed, little may be gained from the recent expansions of Medicaid for pregnant women and children in

"EXISTING FRAGMENTATION IS A MONUMENT TO THE SINGLE-ISSUE POLICIES AND SINGLE-ISSUE SOLUTIONS THAT DOMINATE SOCIAL POLICY IN AMERICA...POLICIES AND PROGRAMS FOR CHILDREN ARE DRIVEN LARGELY BY POLITICAL DEFINITIONS OF THE PROBLEM AND ADMINISTRATIVE DEFINITIONS OF THE SOLUTION...RATHER THAN A CONSIDERATION OF THE AGGREGATE POLICY ENVIRONMENT.

(Kirst, *Rethinking Children's Policy*, p. 3)

states that do not reduce the complexity and length of the eligibility and application process. Also, unless eligibility is coupled with other mechanisms to assure that services exist, even the most determined families will fail to receive the services they need for a healthy birth outcome or a healthy childhood.

Paving clear roadways between pregnant women, children, and services they need means eliminating the myriad barriers to care. Identifying them is not hard — they are everywhere. Actually removing them can be a complex process, but a necessary one if universal access to care is to become a reality.

Roadblocks to Coordination

Not only do women and children face barriers to care, there also are barriers between the programs themselves. Integrating and simplifying services means grappling with the history of how the programs developed and how they do and do not work together.

Federal, state, and local governments have typically responded to one health or social crisis at a time. As the size of government and the number of programs have increased over the years, so has the fragmentation between these programs, both vertically — between the federal, state, and local levels, and horizontally —between administrating agencies and service providers.

As a result, programs are administered by multiple agencies, which use multiple funding streams, as well as different definitions, terminology, and factors for determining eligibility and benefits. For example, at the federal level, although Medicaid and the Maternal and Child Health Services Block Grant are both within the Department of Health and Human Services, they are administered by separate agencies, each with its own regulatory requirements. The WIC and Food Stamp programs are administered by a completely different federal agency, the U.S. Department of Agriculture. Fragmentation is amplified at the state and local levels where programs are, once again, redistributed among agencies.

Legislative committees also operate on separate tracks. Jurisdiction over related programs often falls to different committees with little or no contact between them. For example, one committee may oversee maternal and child health programs, one or two others may address substance abuse issues, and yet another may cover health financing programs, such as Medicaid. When an issue arises such as how to treat drug-addicted pregnant women, formulating comprehensive, effective policies is difficult.

Paving the Way

Although neither the barriers to care nor the lack of coordination between programs is new, their disturbing impact on those in need of services has height-

ened interest in finding ways to improve service coordination and delivery. Demonstration programs, such as those sponsored by federal agencies like the Office of Substance Abuse Prevention, the Maternal and Child Health Bureau, and the Health Care Financing Administration, plus private foundations, are testing various approaches to delivering comprehensive services to targeted groups of women and children. Legislation, such as the recent expansions of Medicaid eligibility and services for pregnant women and children, also has led to efforts at the state and local levels to provide integrated, comprehensive services.

One-stop shopping may sound novel, but the concept is not new. In 1971, for example, then Secretary of Health, Education and Welfare, Eliot Richardson, explained that "service integration is not a new program to be superimposed...rather it is a process aimed at developing an integrated framework" (*Improving* MCH/WIC *Coordination, p.* 9).

Through the years, federal efforts to promote coordinated maternal and child health services include the Maternal and Infant Care and Children and Youth projects in the 1960s. Both introduced new methods of organizing and delivering multiple services to high-risk women and children, usually at one neighborhood location. In the 1970s, the Improved Pregnancy Outcome Program began. Its goal was to improve access to comprehensive services and reduce infant mortality by coordinating preventive, primary, and referral care for mothers and infants. While only a few of these projects and programs still exist, the concepts they pioneered continue to spur the development of comprehensive maternal and child health care delivery systems.

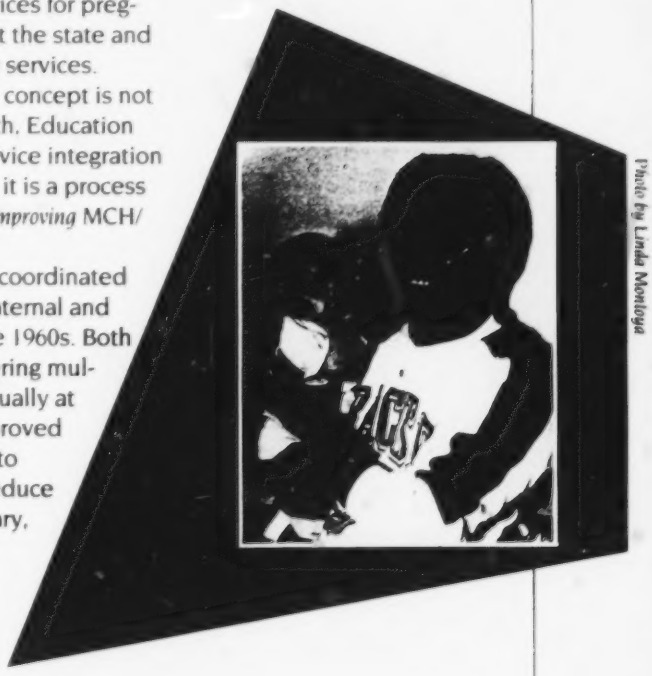


Photo by Linda Montoya

Clearly, there is enough knowledge to end the cumbersome, inefficient "business as usual" approach of delivering maternal and child health and related services. Experiences such as Jolene's do not have to be the norm. The tools are at hand, but we need the commitment from policy makers, program administrators, community leaders, and those on the front lines to build the road to one-stop shopping.

WAKE UP IN THE SHELTER. TAKE A TRAIN TO THE WELFARE OFFICE. WAIT AN HOUR. LEARN THAT THEY HAVE LOST YOUR PAPERWORK. TAKE A BUS TO THE HOSPITAL FOR A CLINIC VISIT. WAIT ANOTHER HOUR. PICK UP YOUR KIDS AT SCHOOL. TAKE THE BUS TO APPLY FOR SPACE IN A HOUSING PROJECT. TAKE THE KIDS ON THE TRAIN BACK TO THE SHELTER....THIS IS HOW WE HANDLE THE DELIVERY OF SOCIAL SERVICES TO THE POOR.

(*Quindlen, A Kind Place*)

What Is One-Stop Shopping?

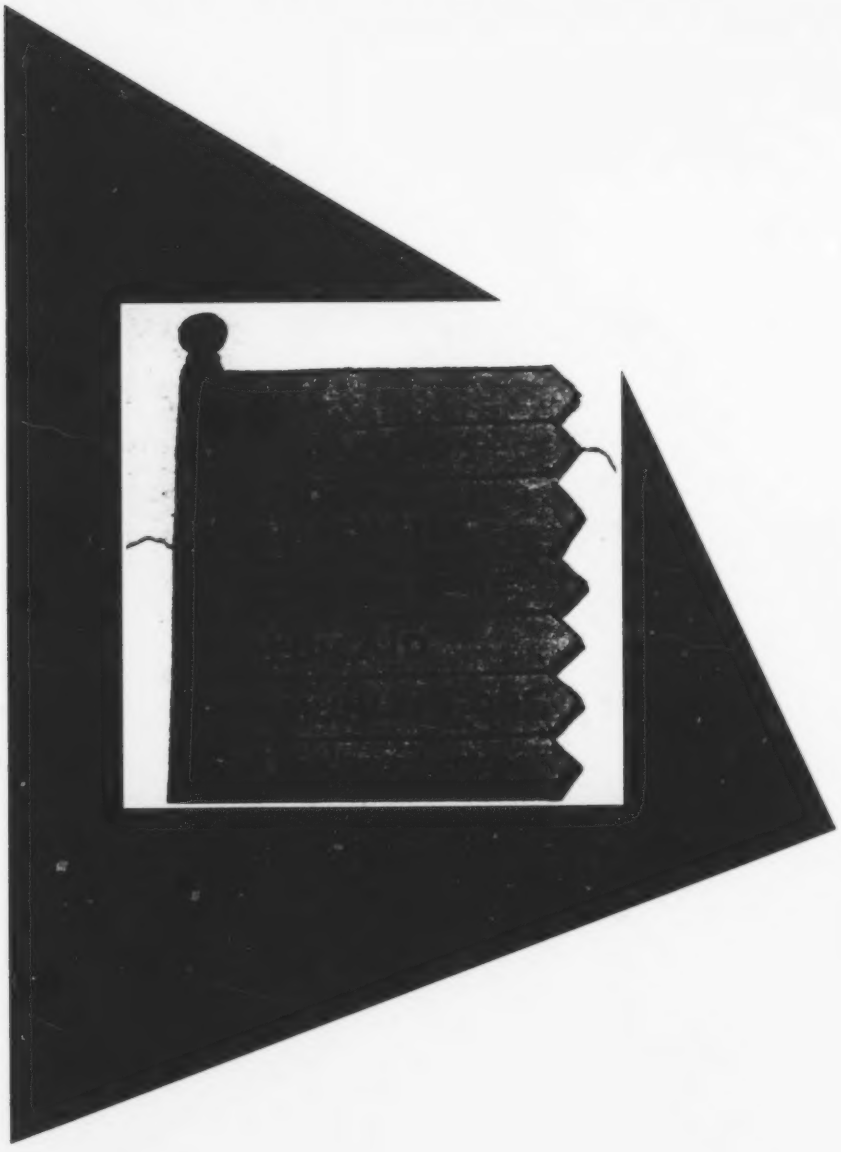
The National Commission to Prevent Infant Mortality believes that **one-stop shopping is a strategy to accommodate the needs of pregnant women and their families, rather than leaving them to navigate through a maze of application forms and services. One-stop shopping strategies should help locate, enroll, support, motivate, educate, advocate, and provide services for pregnant women, new mothers, and their families.**

One-stop shopping is a strategy that coordinates and integrates health and social services so that the system can be accessed at a single point of entry. The entry point can be any place in the system — from an application for a public assistance program to a visit to a health clinic. Once a pregnant woman or child has sought a service, they should be able to easily utilize several.

Just how to map out an effective one-stop shopping plan varies from community to community. The next section of the report, "Designing One-Stop Shopping," describes methods others have used successfully. Although they will be discussed separately, they are not mutually exclusive. The different methods focus on coordinating and linking the program eligibility, application, and service delivery systems with those who need the services.

PART II

DESIGNING ONE-STOP SHOPPING



Although the components of any one-stop shopping strategy will be unique, several generic tools are necessary to design and build the roadways between programs, services, and families in need. First and foremost, **leadership** on the part of policymakers, program officials, and communities is a fundamental building block.

In addition, several tools are needed to assure that a woman and her children not only get on the road to services, but that they also can find their way from one to the next. **Simplifying the route** means facilitating the eligibility and application processes and using outreach to alert women to the importance of prenatal care. Once they are on the road, **bridges must be built and short cuts can be designed** to enable them to travel between services. Finally, once at their destination, services must be available and appropriate. Thus, **building the system's capacity** must also be an integral part of a one-stop shopping strategy.

Photo by David Heller

Leadership

"Having one of the highest infant mortality rates in the country was the best thing that happened to us," explained one North Carolina maternal and child health proponent. Sadly, it often takes a crisis situation, such as a soaring infant mortality rate, to spur policy changes.

The impetus and leadership for one-stop shopping must come from several places. In communities across the country, people with the insight to know what is needed and the ingenuity and commitment to make it happen have taken action. Marty Hackett, Director of the Obstetrics and Gynecology Unit in Boston's South Cove Community Health Center, is one example of a person who credits "knowing how to make noise and going after what you want, regardless of red tape," as the key to the success of South Cove's one-stop shopping strategy (see Appendix).

Political leadership also plays an important role in developing coordinated service systems. Policy changes and program enhancements can provide impetus for a community to take action. Follow-through on a new policy is essential to ensure that its intentions translate effectively to the direct service level. For example, financial eligibility for care alone does not guarantee access or availability of services.

Simplifying the Route

Manning Pellanda, Program Manager in the Washington State Division of Medical Assistance, explains that "the old school of thought was that completing the application process was the client's responsibility. But, when First Steps passed (a state-wide program to publicize Medicaid expansions and the importance of prenatal care) the new message was 'serve pregnant women as quickly as possible and get them into prenatal care.'"

As federal and state initiatives to draw more women and children into care clash with traditionally complex application and eligibility processes, innovative approaches to reconciling the two are emerging. Examples include shortening application forms, developing joint application forms, expediting eligibility determinations, and computerizing applications and client records. Extensive outreach programs further simplify the route.

Shortened Applications. A 1988 survey by the National Governors' Association found that Medicaid applications averaged 14 pages in length, with some as long as 40 pages. As of July 1990, twenty-five states had shortened application forms for pregnant women and children. By July 1, 1991, all states must use shortened forms for this population, at least when they apply at qualifying hospitals and health centers (Public Law 101-508, the Omnibus Budget Reconciliation Act of 1990).

Joint Application Forms. "How many places and how many times should we make a woman prove she's poor?" asks one maternal and child health advocate. Many efforts are underway to consolidate the application process for multiple maternal and child health assistance programs.

At the federal level, as required by Public Law 101-239, the Omnibus Budget Reconciliation Act of 1989 (OBRA-89), the U.S. Department of Health and Human Services is developing a model joint application form for pregnant women and children less than six years old. The form, scheduled for completion in early summer 1991, combines seven programs: Medicaid, the Maternal and Child Health Block Grant program, WIC, Head Start, Community Health Centers, Migrant Health Centers, and the Section 340 Health Care for the Homeless Grant program.

Although the form is intended to serve as a model for states, a few states have already developed joint application

Vermont Department of
Health & Social Welfare

WIC/MEDICAID/DR. DYNASAUR PROGRAM APPLICATION

(Medicaid application only for pregnant women and children born after 9/30/83)

DSW/VDH 0108
R 11/90

Name _____
First name Initial Last name Social Security number Birthdate Telephone number

Address _____
Street City State Zip Code Town of Residence

Directions to your home _____

1. List all household members

First name	Middle	Maiden	Last	Social Security number	Birthdate	Relationship to you	U. S. Citizen
							[ ]Yes [ ]No
							[ ]Yes [ ]No
							[ ]Yes [ ]No
							[ ]Yes [ ]No
							[ ]Yes [ ]No

(Use another sheet of paper for additional household members)

Answer the following for all household members listed above:

2. Is anyone on Medicaid? [ ]Yes [ ]No – do you want health coverage for pregnant member(s) and children under age 7? [ ]Yes [ ]No
3. Would you like to apply for other types of assistance including Medicaid for other members of your household? [ ]Yes [ ]No

DSW forms given by (initials) _____ date _____

4. Does anyone have unpaid medical bills incurred in the past three months? [ ]No [ ]Yes
5. Is anyone pregnant? [ ]No [ ]Yes – who _____ medically verified? [ ]No [ ]Yes
6. Is anyone on WIC? [ ]Yes [ ]No – do you want WIC? [ ]Yes [ ]No
7. Have you received services from the Health Department before? [ ]Yes [ ]No
8. Does anyone have any health insurance coverage? [ ]No [ ]Yes – answer the following:

Name of policy holder Name of insurance company Group number Policy number Effective date

Is any prenatal care covered? [ ]Yes [ ]No

Covered members: _____

9. Does anyone pay room and board? [ ]No [ ]Yes – who _____ $_____ How often? _____
10. Does anyone in your household pay alimony, child support or day care? [ ]No [ ]Yes – answer the following:

Name _____ Type _____ Amount $ _____ How often? _____

11. Income: Type – check "yes" or "no"

		Who received the income?	Gross amount	How often received?
ANFC	[ ]No [ ]Yes –	_____	$_____	_____
SSI or Social Security	[ ]No [ ]Yes –	_____	$_____	_____
Wages	[ ]No [ ]Yes –	_____	$_____	_____
		_____	$_____	_____
Self-employment	[ ]No [ ]Yes –	_____	$_____	_____
Unemployment	[ ]No [ ]Yes –	_____	$_____	_____
Child Support	[ ]No [ ]Yes –	_____	$_____	_____
Day Care	[ ]No [ ]Yes –	_____	$_____	_____
Room and Board	[ ]No [ ]Yes –	_____	$_____	_____
Any other – specify type:				
_____	[ ]No [ ]Yes –	_____	$_____	_____

Please read the statements on the reverse and sign this application

PAGE ONE OF VERMONT'S TWO-PAGE JOINT APPLICATION FORM.

forms on their own. According to a 1990 survey by the Association of Maternal and Child Health Programs, five states (Georgia, Kentucky, Texas, Vermont, and Washington) have developed joint forms, and fourteen others are in the process of creating one. The programs most frequently covered by these applications are Maternal and Child Health Block Grant programs, Medicaid, and WIC.

Joint application forms can save time and money. John Petraborg, Assistant Commissioner of Family Support Programs in Minnesota, estimated that their new Combined Application Form (CAF) — which includes the Food Stamp program, Cash Assistance, and Medical Assistance (Medicaid) — would eliminate the need for 100 other state and county forms.

Expediting Eligibility. The complexity and length of the eligibility determination process for Medicaid stands as another roadblock to care. Several strategies are available to facilitate this process, particularly for pregnant women. Presumptive eligibility, that is, granting temporary eligibility to pregnant women while their formal applications are being reviewed, and other eligibility processes that give priority to applications filed by pregnant women, can help eliminate these barriers. As of July 1990, nearly forty states had adopted one of these methods to help get pregnant women into care more quickly.

Computer Systems. According to Ned Wollman, Chief of the Maryland Division of Eligibility Services, Medical Care Policy Administration, "[public assistance] programs are so complex — there are so many rules, books, and eligibility requirements — that automated systems have become a necessity rather than a luxury." Many others agree and have invested time and money developing automated systems.

Eligibility workers type in the applicant's data, and the computer determines the programs for which she qualifies. In Maryland, that print-out becomes the application when the applicant signs it. Shortly thereafter, a notice is sent alerting her to the programs for which she and her family are eligible.

Other computer systems enable providers to track an individual's participation in multiple programs. In Missouri, for example, personal computers and printers are located in local public health offices. When a pregnant woman comes in for services, the provider can use a tracking number to identify which services and programs she is using and which she still needs.

A common — and legitimate — concern about computer systems is confidentiality. Programs must take pains to ensure that only designated providers and agencies have access to the records. Delaware, for example, has individual confidentiality agreements with each computer-linked program which all employees must sign. The system passwords also change frequently.

Another concern is the cost of devising such a system. It often takes considerable planning and investments of time, staff work, and money. A few states have acquired supplemental funding, such as a federal SPRANS grant from the Maternal and Child Health Bureau in the Department of Health and Human Services, to support development.

IF STATES AND THE FEDERAL GOVERNMENT WANT TO DEVELOP FAMILY-CENTERED AND CLIENT-DRIVEN SYSTEMS RATHER THAN FUNDING-STREAM CENTERED AND ELIGIBILITY-DRIVEN SYSTEMS, THEY MUST FIND WAYS TO MOVE PROGRAM OWNERSHIP TO THE LOCAL LEVEL AND TO SHARE ACCOUNTABILITY AND RESPONSIBILITIES WITH THE PROGRAMS.

(Testimony of Charles Bruner, Director, Child and Family Policy Center before the Subcommittee on Children, Families, Drugs and Alcoholism, Senate Labor and Human Resources Committee, February 20, 1991)

Outreach. Many high-risk women have never learned about the importance of prenatal care. Others who have often do not know how or where to obtain care. Aggressive outreach efforts that address the "who, what, where, why, and how" of prenatal care help bridge the gap between programs and the families who need them. As a start, in any community, a resource directory of local maternal and child health services, ranging from prenatal care providers to assistance in acquiring housing, can be compiled and will greatly benefit both providers and clients. Other outreach strategies include:

- **Public awareness campaigns** involving both the public and private sectors. Examples include television and radio public service announcements; posters on all public transportation vehicles; toll-free hotlines; brochures about prenatal and pediatric c[illegible]e in grocery stores and other establishments frequented by pregnant women; and automatic refe[illegible]rals to programs for pregnant women who visit emergency rooms and for mothers leaving the hospital with their newborns. In Gadsden County, Florida, for example, after a baby is born, hospitals forward information about the mother and infant back into the county health care system. Providers then assess [illegible]ether the family requires follow-up services. Any one as[illegible]t of a public awareness campaign alone will not succeed in d[illegible]wing families to services. Taken together, however, such campaigns can be powerful tools in a one-stop shopping strategy.
- **Home visiting,** which sends trained workers into families' homes to provide services and information. Home visitors also help link families with the various programs and resources they need. Virginia's Resource Mothers program sends trained women from the community to the homes of pregnant and parenting teenagers to work with them and help them gain access to the care they and their newborns need. The program also encourages the teenagers to return to high school and graduate. The Community Connection Project [illegible] Camden, New Jersey, sends trained community workers in neighborhoods to canvas door-to-door, accompany women to clinic visits and, in general, heighten community awareness about maternal and child health.
- **Outstationing** eligibility workers from programs such as Medicaid and WIC in clinics and other locations. OBRA-90 required that

Medicaid applications be taken and processed in sites other than welfare offices, such as disproportionate share hospitals (those that care for a high percentage of low-income and indigent patients), Federally Qualified Health Centers (FQHC), and "look-alikes" — non-federally-funded health centers that are determined to provide the same range and scope of services as FQHCs. Several states and communities have found that the outstationed Medicaid workers are much more invested in their work than they previously were. Working directly with the applicants enables them to see the fruits of their labor and feel as though they have more of a stake in the outcome.

Building Bridges in the System

Drawing women and children into care is futile without a service delivery system that accommodates their needs. Building bridges between families and services and between programs themselves can be done several ways. One method is home visiting, which was briefly discussed above. Another effective way to build bridges is case management.

Bridging the gap between programs themselves also can be done in a variety of ways. For example, administering agencies can develop formal working relationships or interagency agreements. In some instances, legislation has been the catalyst for collaboration between agencies.

Case Management. According to the National Governors' Association, there are four core elements of most states' perinatal case management program: risk assessment, service planning, coordination and referral, and follow-up and monitoring. Case management, also called prenatal care coordination, has been found to improve access to health care.

Case managers do more than help women over and around obstacles to care. Above all, they strive to take a situation which could end in dependence, and turn it around to foster independence. Case management provides guidance that pregnant women need to navigate the health and social service delivery path.

One example of a state-wide case management initiative is the North Carolina Baby Love Program (see Appendix). Maternity Care Coordinators are located in nearly all local health departments, Community and Migrant Health Centers, and on the Cherokee Indian reservation. In addition to health care services, they help pregnant women secure transportation, enroll in education and job training programs, find housing, locate day care, obtain substance abuse counseling, and develop skills to obtain other services on their own.

Interagency Partnerships. Leadership within public agencies is important to making coordination and integration of programs and services a priority. At the federal level, an example of a collaborative effort is the development of the model joint application form discussed

AGENCIES....SELDOM SEE EACH OTHER AS ALLIES. OUTRIGHT RIVALRY OFTEN OCCURS WHEN THEY MUST COMPETE FOR SCARCE RESOURCES.... BECAUSE PROVIDERS TYPICALLY CONCENTRATE ON WHAT THEY ARE ABLE TO PROVIDE RATHER THAN WHAT THEIR CLIENTS NEED, THEY ARE UNLIKELY TO DISCOVER ... DIFFICULTIES THAT ARE NOT YET BEING ADDRESSED OR TO JOIN FORCES WITH OTHER AGENCIES TO FILL THESE GAPS.

(*Melaville, What it Takes, p. 7*)

earlier. In addition, the Health Care Financing Administration and the Maternal and Child Health Bureau are working with state Medicaid and Maternal and Child Health officials to assist states in developing comprehensive approaches to improve maternal and infant health. These federal agencies also have established cooperative agreements with the National Governors' Association, the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, and other groups for similar purposes.

States, for the most part, actually administer maternal and child health programs. Since administrative approaches vary from state to state, there is no one correct approach to collaboration. In some states, health and social services are all under one umbrella department. In others, they are administered by separate agencies.

One purpose of umbrella agencies is to encourage cooperation, collaboration, and communication. Florida's Department of Health and Rehabilitative Services (HRS) is an example of an effective state umbrella agency that administers all health and human service programs. One of HRS's ongoing efforts is the Improved Pregnancy Outcome Program which provides maternity care, WIC, social services, home visiting, and other needed services to low-income women in all 67 counties.

Other states have chosen to use formal interagency agreements that define the goal of the collaborative effort and the action steps that lead to it. North Carolina's Baby Love Program is supported by an administrative arrangement between Maternal and Child Health, Medicaid, and the Rural Health and Resource Development Agency, as well as a Medicaid-WIC interagency agreement and interagency agreements with other programs such as Food Stamps and Head Start.

Legislation can also serve as either a "carrot" or a "stick" to foster cooperation and collaboration. Most significantly, Part H of the Individuals with Disabilities Education Act (Public Law 101-476), initially passed by Congress in 1986, called for all the states to establish comprehensive, multi-disciplinary systems of early intervention services for infants and toddlers with disabilities. If a state chooses to participate, the legislation requires the state to set up a 15-member interagency coordinating council, authorizes planning funds for the state, and gives guidance to the state for developing the service system for these children.

In some instances, these types of agency collaborations work well. In others, they end up as mere window dressings. The key to

success is for the leadership and staff of each agency to be willing to move beyond differences, learn each other's "languages," and share in both the successes and failures of their combined efforts.

Designing Short Cuts

Sometimes, co-locating multiple services under one roof can enhance service delivery, especially for at-risk populations. However, co-location itself is not one-stop shopping. Simplifying the application and eligibility processes, bridging gaps between services, and removing other roadblocks described earlier, are all important components for one-stop shopping strategies. As explained by Deborah Clendaniel, Administrator of Delaware's Nutrition Program, "If a woman still has to make several trips to the center to receive services for herself and her children, has to pay $5 for transportation each time, and perhaps miss work or school, access is not improved. A one-stop system means that she can come in one time and receive all or most of the services."

Sites that lend themselves to one-stop shopping include Community and Migrant Health Centers, state and local health departments, clinics, and hospitals. One-stop shopping strategies can capitalize on the fact that most of these locations already house multiple services and resources. Although rare, some communities have actually constructed centers specifically for co-locating programs.

Community and Migrant Health Centers. For over 25 years, Community and Migrant Health Centers have helped increase access to quality health care for low-income and uninsured families. More than 550 health centers supported by these two federal programs provide preventive and primary health care to many people who would otherwise lack access to services due to geographic isolation, scarcity of providers, or lack of financial resources. Since 1987, the Comprehensive Perinatal Care Program has provided funds to several health centers to improve and expand maternal and infant health services. However, the funding is limited and does not nearly reach all who are in need.

Because health centers are community-based, they can target a specific population, such as drug-addicted pregnant women. Dr. Elizabeth Brown directs such a program for pregnant addicted women in Dorchester, Massachusetts. She explains that, "These women have low self-esteem and live disorganized lives, often involving physical or sexual abuse. Such a lifestyle is not conducive to finding baby sitters, arranging for transportation, or being on time for appointments. We must provide services to meet their special needs, thus eliminating many of the reasons for missed appointments. This may entail meeting mental health and social needs, as well as medical ones." (see Appendix)

Public Health Departments and Clinics. In some states, health departments provide direct services and may also house program offices where applications are processed and eligibility

determinations made. North Carolina is one state that has taken advantage of these circumstances by placing Maternity Care Coordinators in this service-rich setting. Maternity Care Coordinators are the bridge between the pregnant women and services, both within and outside the health clinic.

Hospitals. Particularly in areas already lacking sufficient primary care services, such as rural and inner-city areas, hospitals are one of the few existing health care facilities. Bringing additional providers into a hospital setting can reduce barriers to care and augment the number of on-site services and programs. One innovative hospital-based program in Tampa, Florida, called Genesis: A Health Care Center for Women and Children, has added transportation, child care, and other services that meet the needs of its low-income, high-risk population of pregnant women and their families (see Appendix).

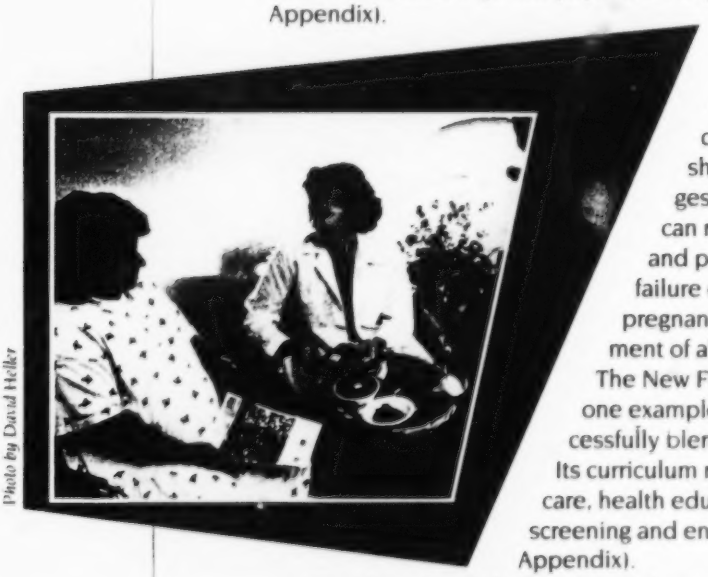


Photo by David Heller

New Structures. Although not common, some communities have actually built completely new structures to house one-stop shopping programs. Schools have been suggested as a site where health and social services can merge for children in general, or for pregnant and parenting teenagers in particular. However, the failure of regular schools to meet the needs of pregnant and parenting teens has led to the establishment of alternative high schools in some communities. The New Futures School in Albuquerque, New Mexico, is one example of an alternative high school that has successfully blended education and comprehensive services. Its curriculum ranges from high school classes to prenatal care, health education, parenting skills development, WIC screening and enrollment, child care, and transportation (see Appendix).

On a broader scale, because Delaware had no adequate local health or social service sites when it decided to establish a statewide, comprehensive public service program, the state established State Service Centers. These Centers were constructed, rented, or renovated buildings and are now located in communities statewide. According to state officials, this investment has improved and enhanced service delivery throughout the state (see Appendix).

Building the System Capacity

In the same way a Medicaid card does not mean that access to care is guaranteed, building and simplifying the route to care will not guarantee access either without an adequate supply of providers or service delivery sites. Part and parcel with designing a one-stop shopping plan is building the capacity of the service delivery system.

The lack of physicians in underserved areas and many physicians' unwillingness to take Medicaid patients have been longstanding problems. This is especially significant with obstetrics and is a growing issue for pediatrics. Federal programs such as the National Health Service Corps and Community and Migrant Health Centers have been highly effective in building the capacity in many rural and inner city areas, but they are unable to fully meet the need due to funding limitations. The Department of Health and Human Services, state Medicaid agencies, and physician groups are working to encourage providers to take Medicaid patients by reducing the administrative, reimbursement, and other obstacles to participation.

Certified nurse-midwives and nurse practitioners can and do provide high quality primary care. However, state practice laws, some physicians' and hospitals' concerns about working with these practitioners, and their overall small numbers limit their ability to fill the need.

Malpractice concerns of maternity care providers have led many to abandon or limit their obstetric practices. Legislation has been introduced in Congress to address the malpractice issue, and virtually all the states have responded with initiatives, such as assisting physicians in paying their insurance premiums and indemnifying physicians who participate in public programs. In North Carolina, the Rural Obstetrical Care Incentive Program, started in 1988, compensates family physicians, obstetricians, and certified nurse-midwives who provide maternity services in medically underserved areas. Funds appropriated by the General Assembly are used to help offset the cost of malpractice insurance premiums.

YOU HAVE TO DESIGN YOUR SERVICE PROGRAM AROUND THE NEEDS AND CHARACTERISTICS OF THE CLIENTS, RATHER THAN AROUND THE HABITS AND TRADITIONAL ORIENTATION OF THE PROVIDERS.... THE BEST WAY TO ACCOMPLISH [THIS] IS TO START DEVELOPING A SERVICE FOCUSED ON WHERE THE CLIENT IS RATHER THAN ON PRESENT PROFESSIONAL ROUTINES OR PAST PATTERNS OF BEHAVIOR.

(*Bruce Vladeck, President, United Hospital Fund, "Medicine and Health Perspectives," January 21, 1991.*)

Case Study

In July 1990, Jolene again suspected she was pregnant. She returned to the Women's Center for testing, now offered five days a week. When told she was pregnant, she also received counseling, health education, and an appointment for prenatal care. The local public health clinic was now a one-stop shopping program for pregnant women and offered several services during each woman's first visit, including financial eligibility determination for all services such as WIC; presumptive eligibility for Medicaid; plus a face to face interview with an outposted Medicaid eligibility worker; expedited eligibility for Food Stamps; an initial nursing assessment with education and lab work for prenatal care; and HIV testing. Postpartum/family planning services are also provided at the Women's Center every day of the week.

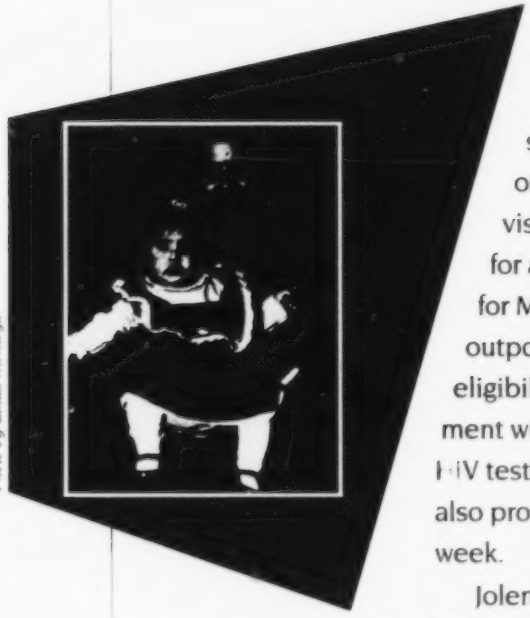


Photo by Linda Montoya

Jolene must still visit the University to have her eligibility for hospitalization determined. All she needs is proof of Medicaid eligibility and a 10 minute interview at the hospital. (Previously, each woman had to attend a 45 minute interview and bring extensive documentation on income and residence). This time, Jolene made only 3 visits and began care in less than a week.

Conclusion

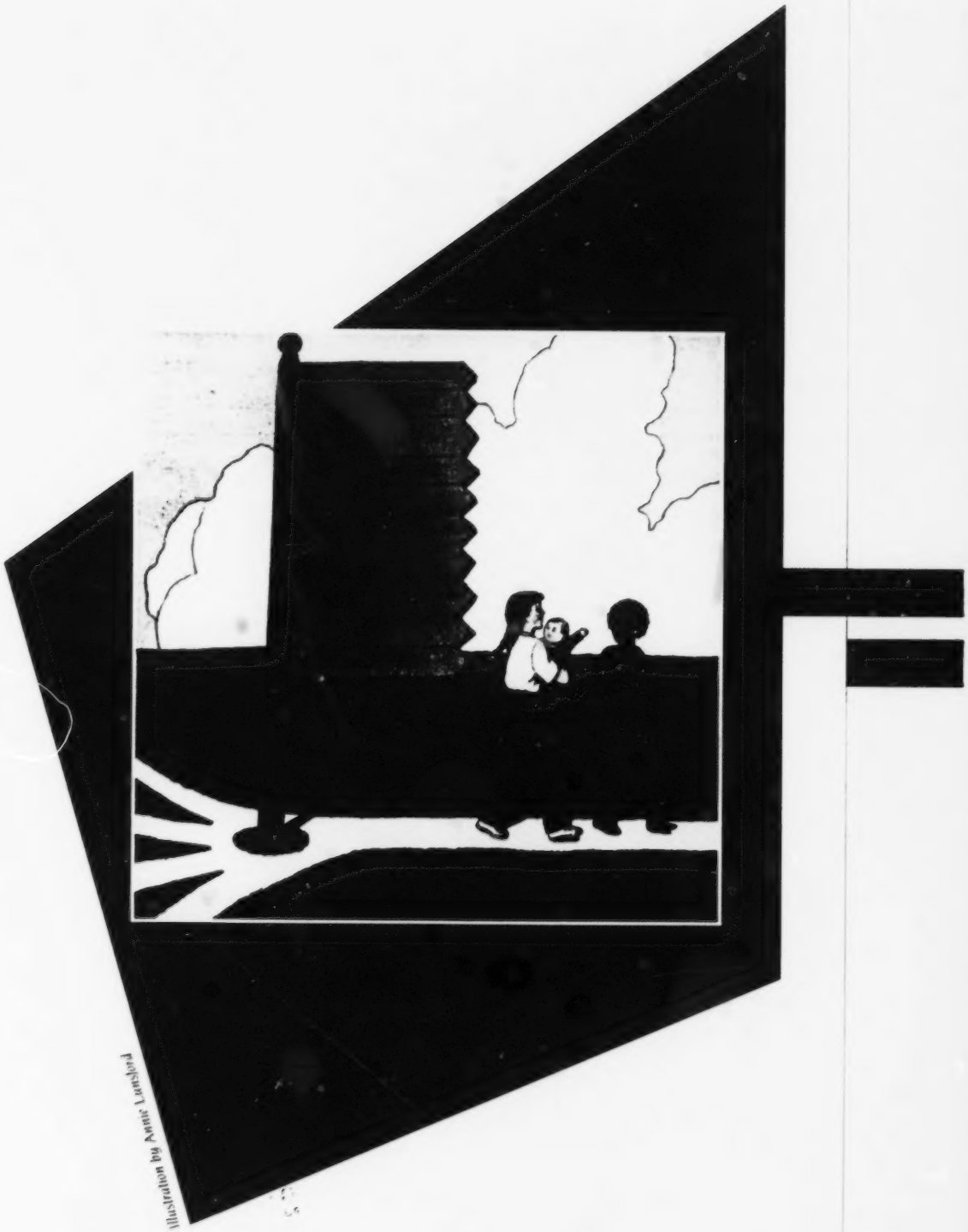


Illustration by Annie Lunsford

The National Commission to Prevent Infant Mortality views the lack of universal access to prenatal care as a major contributor to the United States' dismal infant mortality and morbidity rates. One important way to achieve universal access is through one-stop shopping, that is, integrating and coordinating services for pregnant women and children.

Because federal, state, and local governments have typically responded to one health or social crisis at a time, we find ourselves with a public service delivery system that resembles an obstacle course, especially for the most needy populations. Programs targeting low-income pregnant women and their children are administered by different agencies, each with its own funding stream, definitions, terminology, locations, and methods for determining eligibility and benefits. The result is that the families who need health and other related services often confront a labyrinth too difficult and frustrating to navigate.

Our current "system" is based on a habit of "ignoring safety measures at the launch site and mobilizing resources only for the crash landing." (Schorr, *Within Our Reach*, p. 65) Making a significant, lasting change will require repaving the streets, improving the signs, and redesigning the road map. Progress has begun with some agencies at the federal and state levels working together, many for the first time. In several communities, people are rolling up their sleeves to work toward making a difference. As exemplified by the innovative strategies discussed in this report, we know how to bridge the gaps between programs and between families and services. Investing in these preventive strategies, that is, repairing the launch site now, while not simple, will save lives and money down the road.

We cannot afford to wait any longer. A national commitment to provide universal access to all pregnant women and children will provide the fuel; each of us has a role to play in redesigning the road map. We hope this report will help spur the commitment and leadership necessary to make one-stop shopping the norm, rather than the exception.

RECOMMENDATIONS

Leadership

- Federal and State government should make one-stop shopping and the integration of services for childbearing women and children a high priority, both in policy development and program management.
- The U.S. Congress and state legislatures should develop collaborative relationships between the committees with jurisdiction over programs that serve pregnant women, infants, and children for the purpose of assuring that legislation encourages the integration of services rather than further fragmentation.
- Local leaders, including mayors, businesses, religious groups, and civic organizations, should work to make the integration of services a priority goal for their communities.

Designing One-Stop Shopping

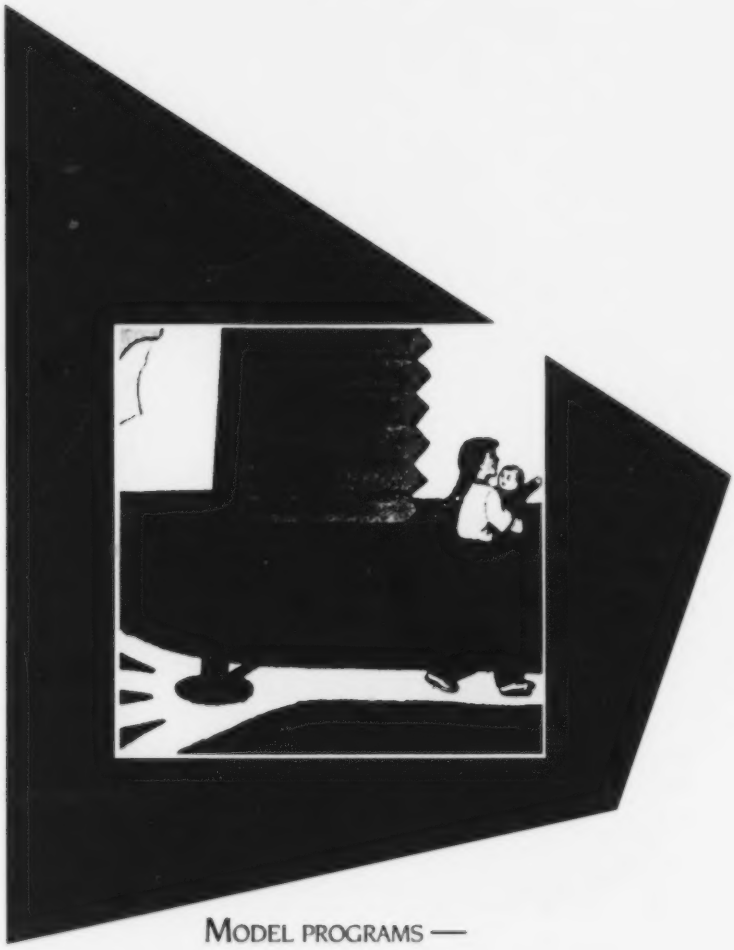
- Federal and State agencies serving pregnant women and children should examine program eligibility and application processes and promptly work to streamline, simplify, and integrate them.
- States should outstation program eligibility workers at service locations and encourage the use of "generic" eligibility workers who would be trained to take applications for a variety of programs, such as Medicaid, WIC, and housing. States should also consider allowing applicants to mail their completed forms to the eligibility office.
- Governors should develop interagency coordinating councils and other strategies to improve communication and collaboration and to provide technical assistance to communities to encourage the development of one-stop shopping strategies.
- A national clearinghouse should be developed for information on the "how-to's" of one-stop shopping including model applications, systems development, public and private funding sources, effective outreach and public awareness strategies.
- State Medicaid programs should adopt the eligibility and services options enacted by Congress that are targeted to pregnant women and children. States should consider using presumptive eligibility and case management, plus home visiting, transportation assistance, and other services.
- Aggressive outreach and public awareness campaigns, using public resources as well as private initiatives, such as the Blue Cross and Blue Shield Organization's "Caring for Tomorrow's Children" campaign, should be implemented to alert pregnant women to the importance of prenatal care and how and where to obtain services.
- Federal and state policy and program officials should examine current funding mechanisms of programs serving women and children and develop innovative approaches for integrating and coordinating services.

- All hospital discharge plans for new mothers should include automatic referrals to a one-stop system which includes postpartum care, family planning, well child care, immunizations, and social support services as needed. Pregnant women or children seen in an emergency room who do not have a maternity or primary care provider should also be automatically referred to a one-stop shopping system.
- Communities should develop resource directories of health, social, and other related services for women and their families. Local programs as well as state and national information should be included and the directories made available to providers and families.

Designing Short Cuts

- Congress should appropriate funds to the full authorization level for the Maternal and Child Health Block Grant, not only to build system capacity overall, but also to trigger the initiation of one-stop shopping programs which were authorized in the Omnibus Budget Reconciliation Act of 1989.
- Home visiting for pregnant women and infants should be established through both the public and private sectors for the purpose of reaching at-risk families, linking them with the community services and resources they need, as well as providing services directly in the home. Programs could be initiated through Medicaid, Community and Migrant Health Centers, the Maternal and Child Health Block Grant program, schools of nursing, Y.M.C.A./Y.W.C.A.s, and others.
- Congress should continue to increase funding for the National Health Services Corps, and provide assistance to Community and Migrant Health Centers with their malpractice insurance costs so that the millions of dollars annually spent on malpractice coverage could be redirected to expanding and coordinating services for pregnant women and children served by these centers.
- Congress should establish optional Medicaid coverage of non-hospital residential alcohol and drug treatment for pregnant women and their children. Congress should also clarify the extent to which states can already cover outpatient alcohol and drug treatment services for this population under various service categories. Such services should be an integral part of one-stop shopping systems.
- States should encourage the use of certified nurse-midwives and nurse practitioners to deliver maternity and primary pediatric care.
- Civic groups should help to establish networks for integrating and enhancing community services for women and children. Examples include assistance with child care and transportation, as well as assisting in setting up services in a one-stop shopping site, such as job counseling, financial advice, reading and writing skills development, child care, among others.

APPENDIX



MODEL PROGRAMS —

NO MATTER HOW SPECIAL THEIR CIRCUMSTANCES

— BRING HOME THAT, EVEN IN AN IMPERFECT

WORLD, SOMETHING CAN BE DONE TO ADDRESS

CERTAIN SEEMINGLY INTRACTABLE SOCIAL

PROBLEMS. THEY PROVIDE A VISION OF WHAT CAN

BE ACHIEVED...A TAKEOFF POINT IN THE SEARCH

FOR BETTER UNDERSTANDING OF THE ELEMENTS

OF INTERVENTIONS WORTHY OF WIDESPREAD

IMPLEMENTATION.

(*Schorr, Within Our Reach, p. 266*)

Photo by Bob Grove

WE NEED BETTER COORDINATION BETWEEN THE STATE AND FEDERAL GOVERNMENTS....AND WE NEED BETTER COORDINATION BETWEEN THE STATE HOUSES AND LOCAL COMMUNITIES. COMMUNITY-BASED PROGRAMS ARE THE HOPE, THE GLIMMER OF LIGHT, THAT MAKE ME FIRMLY BELIEVE WE CAN TURN THE SITUATION AROUND FOR PREGNANT WOMEN AND CHILDREN.

Lawton Chiles, Governor for the State of Florida

Chairman, National Commission to Prevent Infant Mortality

FAMILY LIFE PROGRAM

SITE: Developed at Boston City Hospital and run through the Harvard Street Neighborhood Health Center in Dorchester, an impoverished community with heavy drug activity.

PROGRAM DESCRIPTION: Massachusetts, like many other states, lacks treatment programs to serve its growing population of drug- addicted pregnant women. The Family Life Program is a model neighborhood-based comprehensive day treatment program for drug-addicted pregnant women and their families in Dorchester.

Funded by a five year grant from the National Institute on Drug Abuse, the project's objective is to test whether a day program — for which costs would be greater than a traditional outpatient program, but less than a residential program — improves pregnancy outcome and long-term compliance with drug treatment. If so, the plan is for the program to be replicated and integrated into community health centers across the country.

The Family Life Program is based on the premise that drug-addicted women — particularly pregnant ones — need services that go beyond the specific drug addiction. Many women who use drugs during pregnancy have psychosocial problems, are young and unmarried, lack adequate financial and social resources, and are ill-prepared to face the responsibilities and demands of motherhood. The Family Life Program provides multiple, carefully scheduled services on-site. They include day treatment for substance abuse; prenatal care and classes, postpartum obstetric care; pediatric primary care; parenting education including child development; nutrition and parenting skills development; early intervention programs for young children; child care; transportation; and advocacy services. Advocacy services range from instruction in cooking nutritious meals on a hot plate and an on-site laundry, to a literacy training program leading to high school equivalency certification.

Systems coordination includes a referral arrangement with centers in Boston where drug-addicted pregnant women receive either addiction services or prenatal care. Because the Family Life Program is affiliated with a neighborhood health center, women have access to other auxiliary programs such as job training and youth projects, for example. A van, acquired specifically for the program, provides transportation to and from the Center.

Women attend programs for several hours each day, at least three days per week. The Center is open in the evening so that the women can socialize in a drug-free environment.

The program is fairly new and, to date, four of the 5 babies born in the program have been full-term. All five are normal, healthy and drug-free. Evaluation of treatment outcomes for mothers and infants will be done on a regular basis.

THE BABY LOVE PROGRAM

SITE: The State of North Carolina

PROGRAM DESCRIPTION: The Baby Love Program was introduced in October 1987 to combat North Carolina's high infant mortality rate — among the highest in the country. Baby Love strives to improve health outcomes by increasing access to health care and support services for low-income pregnant women and children across the state. It combines co-location and system linkages.

North Carolina adopted federal options aimed at expanding Medicaid benefits to uninsured low-income pregnant women. Effective October 1, 1987, an additional 15,500 low-income pregnant women and 23,000 children (ages 0-2) with family incomes at or below 100 percent of the federal poverty level became eligible for coverage. By October 1990, the program had been further expanded to cover pregnant women and infants at or below 185 percent of the poverty level and children up to age 6 with family incomes at or below 133 percent of the poverty level.

Baby Love resulted from a collaborative state effort to implement a comprehensive system that: 1) encourages clients to utilize the new benefits; 2) simplifies and speeds up the eligibility process; 3) helps pregnant women receive packages of health and social services; 4) stimulates community agencies to coordinate service delivery; and 5) provides methods to quantify, report, and advocate for new policies and procedures that fill gaps in the system. A unique administrative arrangement between the Maternal and Child Health, Medicaid, and Rural Health and Resource Development agencies operate this state-wide program.

The key to Baby Love's success are "Maternity Care Coordinators." Maternity Care Coordinators are located in virtually all local health departments, community and migrant health centers, and in the Cherokee Health Delivery System. They provide the link between services and act as professional client advocates by helping women make application to Medicaid; secure transportation for clinic appointments; enroll in education and job training programs; locate affordable housing; obtain food, clothing, and household furnishings; secure day care; stop using tobacco, alcohol and other drugs; and develop the skills that foster independence in utilizing the health and social service delivery systems. Maternity Care Coordinators can thus create service packages that meet the needs of women in their community. Data show that women who received maternity care coordination services had a low birthweight rate 14 percent lower and an infant mortality rate 23 percent lower than women on Medicaid not receiving such services. For 1988, the infant mortality rate was 14.7 for clients who did not receive maternity care coordination and 9.6 for those who did. A cost analysis found that every $1 spent on maternity care coordination saved $2.44 from decreased costs of newborn care.

GENESIS: A HEALTH CARE CENTER FOR WOMEN AND CHILDREN

SITE: Tampa General Hospital, Tampa, Florida

PROGRAM DESCRIPTION: Genesis: A Health Care Center for Women and Children was created to improve access to specialized care for low-income women and children of Hillsborough County (which has the highest infant mortality rate of any urban county in Florida); to reduce maternal and infant morbidity and mortality rates; and to establish a prototype MCH program for the state which demonstrates the cost-effectiveness of a coordinated multi-disciplinary approach. The program has been in full-time operation since January 1990 and projections are to see 2,000 pregnant women per year.

The impetus for developing the Genesis program came from the Authority Board members' concern about the expense of neonatal care that could be saved through better use of preventive services, and by administrative and nursing staff convinced of the timeliness of such a program in the Tampa community. A $1 million grant from the State of Florida enabled Tampa General Hospital to renovate a facility for the program. By bringing care into the middle of a low-income neighborhood, Tampa General sends the message to women that prenatal care is important.

Photo by David Heller

The ambulatory care center offers prenatal, postpartum, family planning assistance and gynecological care; well baby and child health care; nutritional counseling; health education; social services; financial counseling; on-site child care during mother's visits; and education for students in the health field.

Efforts to link services include outreach and case management, as well as transportation assistance to and from appointments. Services are managed by a team of obstetricians, pediatricians, nurses, and social workers. The hospital finances the program's day-to-day operation and provides its staff of nurses, nurse-midwives, and support personnel. Tampa also provides the link to financial and social services counseling through state and local agencies. In coordination with the WIC Program, nutritionists provide counseling. The University of South Florida provides the medical staff for the center.

The evaluation and research components of Genesis are being conducted by contract with the University of South Florida, College of Public Health. Evaluation will focus on birth outcomes and the overall rate of change in the county's pregnancy outcome indicators.

South Cove Community Health Center

SITE: Boston, Massachusetts

PROGRAM DESCRIPTION: What was a small store-front clinic 13 years ago has evolved into the South Cove Community Health Center. With funding from the federal Community Health Center program, including a Comprehensive Perinatal Care Program grant, South Cove has developed a comprehensive service program for pregnant women and their families. The majority of clientele reside in the Greater Boston Asian and South Cove communities. Many live in Chinatown and the surrounding area, although some even come from outside the state. Because certain issues have different meanings in the Asian culture such as child birth, drawing blood, and birth control, South Cove strives to provide services in a culturally-sensitive manner. Care is comprehensive and bi-lingual.

The Center offers bi-lingual health education, prenatal care, labor coaching, postpartum care, family planning services, Thalassemia screening, pediatrics, and mental health counseling. Staff also teach basic "life skills" to women unfamiliar with American society. These include money management, social service access, and using public transportation. To better accommodate the clientele, the staff has translated all informational materials into Chinese and Vietnamese. Staff members speak Cantonese, Toisanese, Mandarin, Vietnamese, Khmer, Tagalog, and Burmese.

Coordinating systems is an ongoing task. South Cove has an arrangement with Beth Israel Hospital to have all deliveries done there. Early intervention (including home visits) are arranged for all infants with problems or disabilities. Outreach is mainly through word of mouth. Staff also visit English as a Second Language (ESL) classes, other service delivery centers, festivals, and other events in the Asian community to publicize South Cove's services.

South Cove has served the Chinese community for many years. A newer program of outreach to the Vietnamese women of Greater Boston began in November 1989 with the support of a grant from Johnson & Johnson. This entails networking with other agencies and providing services to help reach Vietnamese women who are pregnant, as prenatal care is not well understood in their culture. It includes not only prenatal care, but also early parenting classes which serve as a support group for postpartum women. Home visiting services help mothers with their newborns.

Approximately 300 pregnant women are seen each year and in 1989, 53 percent were uninsured, and 83 percent were non-English speaking.

DELAWARE

SITE: State of Delaware

PROGRAM DESCRIPTION: Approximately 15 years ago, officials in Delaware decided to improve access to services. The Department of Health and Human Services (DHHS) administers maternal and child health and social programs such as Medicaid, food stamps, WIC, and Maternal and Child Health. Because service delivery was fragmented, DHHS decided to move all departmental services under one roof in communities throughout the state.

Delaware had no local or county health departments, so State Service Centers were established. Some were newly built, some rented, and some renovated. Most offer well child care, WIC, prenatal care, food stamps, and Medicaid, or a combination of these on site. WIC often serves as the "carrot" that brings low-income women to the Center. Co-location enables the women to receive other maternal and child health services along with it.

Efforts have been made to link the programs systematically. Delaware's Early Pregnancy Screening Project, the result of a federal SPRANS grant, screens women for risk factors for poor pregnancy outcomes. The screening tool is administered anywhere pregnancy tests are conducted, as well as in women's health centers and community health centers. Data from the screening tool is then computerized and women can be tracked through the service system. A woman is contacted at least twice during her pregnancy to ensure she is keeping appointments and to provide help in applying for other services such as WIC and Medicaid.

DHHS also operates an on-line data system. Each individual receiving a department service is registered on the system. WIC, Medicaid, AFDC, immunizations, day care, Food Stamps (and eventually prenatal records and genetics) are all linked to these records. This system eliminates much of the repetition that occurs during basic data collection, allows more time for service delivery, and enhances management of women receiving multiple services.

Delaware uses strict confidentiality measures. All employees with access to computers must sign a confidentiality agreement. The passwords to the various systems change frequently during the year. Many believe computer systems are more secure than other methods — there are no files "lying around," and if a record is left on the screen for several minutes, it fades off.

With Delaware's program, more high-risk women are receiving early and regular care. The WIC Program served 84% of the high risk women and infants. Smart Start (Medicaid Enhanced Maternity Care) served 227 women out of 280 targeted. Of 98 deliveries only 7 percent were low birthweight, the same rate as all deliveries state-wide.

New Futures School

SITE: Albuquerque, New Mexico

PROGRAM DESCRIPTION: The New Futures School evolved from a tutorial program for pregnant teens held in a Y.W.C.A. In response to the growing need for services for pregnant and parenting teens, New Futures has grown into an alternative school of the Albuquerque Public Schools.

The overall goal of N.F.S. is to break the cycle of adolescent pregnancy, child abuse, neglect, illiteracy, and poverty. Specifically, the program seeks to motivate teenaged parents toward completion of their secondary educations, to mature, to have healthy pregnancies and healthy families, and to be responsible parents (which for some may be release for adoption). Funding comes from the Albuquerque Public Schools; New Futures Inc., a non-profit community based organization; the New Mexico Department of Human Services (family services, day care, vendor payments, and a welfare reform pilot project); the New Mexico Health and Environment Department; the Carl Perkins Funds; Joint Training Partnership Act (JTPA); Honeywell Corporation; Public Service Co. of NM; U.S. West; private and civic organizations; and private donors.

Photo by Linda Montoya

N.F.S. offers comprehensive services. Educational services include a comprehensive high-school program, a G.E.D. preparation program, as well as classes in maternal and child health, parenting, and child development. Other services include individual and group counseling, childbirth classes, day care, and vocational education. Through interagency collaborations, N.F.S. has brought in on-site WIC enrollment, a family planning clinic, immunizations, and prenatal care. Volunteers and the Foster Grandparents program contribute significantly to the N.F.S. program.

The school has two major components. A Perinatal Program serves the teen who enters during her pregnancy and remains until the end of the semester in which her child is born. The Young Parents' Center serves the most high-risk group of teenage mothers and fathers — those who are determined unable to successfully participate in a regular school program after the birth of their child. Both provide comprehensive services.

In the past 20 years, over 6,000 adolescents have utilized N.F.S. services. Students are ages 12 through 21. In 1989-90, 60 percent of the students had been drop-outs but returned to school through N.F.S. A 1987 study found that 77 percent of N.F.S. students had a high school diploma or were still in school. Fifty-four percent of graduates had post-secondary education or training. Repeat pregnancy rates for N.F.S. students are half the national rate. N.F.S. students also are only half as likely to give birth to low birthweight babies as are their peers nationally.

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National Commission to Prevent Infant Mortality

The National Commission to Prevent Infant Mortality was established by Congress in 1987 to create a national strategic plan to reduce infant mortality and morbidity in the United States. The sixteen-member Commission includes Members of Congress, the Secretary of Health and Human Services, the Comptroller General of the United States, representatives of state government and experts in the field of maternal and child health.

Knowing that many, if not most, of the answers to how to promote the health of mothers and children have existed for decades, the Commission chose to focus on practical solutions at the federal, state, and local levels for improving the health and well-being of mothers and children rather than create a new body of research.

In August, 1988, the Commission presented its findings to the President and the Congress in the report entitled, "*Death Before Life: The Tragedy of Infant Mortality.*" This report detailed a series of action steps which could be implemented by the public and private sectors.

The National Commission to Prevent Infant Mortality continues its work to create mechanisms for implementation of recommendations contained in the report. Current efforts focus on continuing to bring national attention and a strengthened momentum to activities which promote the health and well-being of mothers and children.

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** At this time, two vacancies exist due to the retirement of Illinois Governor James R. Thompson and Representative Thomas J. Tauke. Their replacements await confirmation.*

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